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Patient Compliance in Drug Therapy for Hypertension

TO THE EDITOR: I am writing in regard to Dr G. N. Aagaard's article on drug therapy for hypertension.[1]

I fully agree it is dangerous to lower blood pressure abruptly, indiscriminately or erratically—especially the latter. Patients who do not accept the idea that blood pressure medication is an on-time-as-directed type of therapy should not be treated. Physicians who will not keep calendar count of refills should not treat hypertension.

The only study that reflects this thinking is the HDFP (Hypertension Detection and Follow-up Program). But the journal's article misses the reason for the different mortality rates in the HDFP study. The author theorizes, "It is possible that the strong psychological and social support given the SC [stepped care] subjects over the five-year study caused the reduction in mortality." The difference between the stepped care and referred care subjects was *compliance*. In this study, compliance was drummed into those patients in the stepped care group only.

The findings I have most faith in are from the combined insurance company study of 20,000 deceased hypertensive patients who were under treatment at the time of death, evaluated from an actuarial point of view. This study came up with the conclusion that the lower the blood pressure, the longer the life span. It did not deal with lowering the blood pressure per se unless the insured died while the pressure was being lowered.

To get the mortality down to 2% to 4% greater than normotensive insured men, the systolic pressure had to be reduced to 137 mm of mercury or less and the diastolic to 73 mm of mercury or less. Curiously, when these two numbers are added together, they total 210 or 2° less than the boiling point of water at sea level in degrees Fahrenheit. This coincidence makes it easy for patients to remember.

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REFERENCE

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Presumed Chlamydial Infections and Treatment of Sexual Partners

TO THE EDITOR: In his discussion of *Chlamydia trachomatis* infections,[1] Martin Quan does a good job of summarizing the clinical features, varied presentations and high incidence. He points out that many practicing physicians, due to the expense and trouble of culturing for *Chlamydia*, will treat presumed chlamydial infections empirically. I thoroughly agree with this. However, he does not touch on an important corollary which is that sexual partners likewise should be treated.

This particular aspect of treating sexually transmitted diseases continues to be a matter of frustration for me. Often, partners of my patients will see another physician who, after a gonorrhea culture is done and found to be negative, will tell that patient that he or she has no sexually transmitted disease. I feel that treating sexual partners is very important and the above scenario makes both the other physician and myself look foolish. I believe that we physicians should be consistent in treating sexual partners of persons presumably infected with *Chlamydia*.

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REFERENCE

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Skin Testing During Pregnancy

TO THE EDITOR: This letter is in response to the epitome "The Radioallergosorbent Test" in the October 1984 issue.

The authors state, "it is generally agreed that skin testing is contraindicated during pregnancy and that RAST [radioallergosorbent test] is an acceptable alternative."

I disagree with this statement. It has been shown in several studies that in general immunotherapy is not contraindicated during pregnancy. Skin tests, if properly performed using scratch or puncture prior to an intradermal test and using the forearms versus the back, run a much smaller risk than immunotherapy; therefore, I do not feel they are contraindicated during pregnancy. It is assumed that an informed consent form has been carefully reviewed with the patient and that medication and equipment are available in case a reaction does occur.

Other than for the possible medical-legal aspects if a reaction does occur, I would be interested in hearing if the authors know of any medical contraindication to the testing during pregnancy.

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REFERENCE

1. Asser S, Hamburger RN: The radioallergosorbent test, *In* Allergy—Important advances in clinical medicine (Epitomes of Progress). West J Med 1984 Oct; 141:511

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Drs Asser and Hamburger Reply

TO THE EDITOR: We know of no medical or biologic contraindication to skin testing during pregnancy. The reasons for that statement in our epitome are the following:

1. Most allergists will not begin immunotherapy injections during pregnancy and therefore postpone skin testing. If a pregnant patient's history suggests that her illness is due to environmental allergens that could be removed with benefit to the patient, the RAST is preferred for confirmation of the clinical impression.

2. Skin testing or immunotherapy injections with their attendant risks of anaphylactic or psychalgic reactions (or both) followed by abortion, miscarriage or the birth of a malformed infant add unnecessary malpractice risk to the practice of allergy.

The precautions Dr Harwell outlines in his letter are those generally applicable to all allergy patients but would not be adequate during pregnancy. We therefore believe